Chemung ARC
Corporate Compliance Plan

May 2017

Note

The original July 2001 Corporate Compliance Plan (CP) was created with Bonadio & Co., LLP. It was approved by the Board of Directors in 2001.

The document was then revised (dated November 2007) and approved by the Board of Directors at the January 24, 2008 meeting.

The Plan was revised again in May, 2008 , September 2009 and February 2011 and May 2017

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CHEMUNG ARC
CORPORATE COMPLIANCE POLICY

1. It has been and continues to be the policy of this Chapter to comply with all applicable federal, state and local laws and regulations, and payor requirements. It is also this Chapter's policy to adhere to the standards of conduct that are adopted by the Board of Directors, the Executive Director and the Corporate Compliance Committee.

2. We have always been and remain committed to our responsibility to conduct our business affairs with integrity based on sound ethical and moral standards. We will hold our staff members, contracted practitioners, and vendors to these same standards.

3. All staff members, contracted practitioners, and vendors shall acknowledge that it is their responsibility to report any suspected instances of suspected or known noncompliance to their immediate supervisor, the Executive Director or the Corporate Compliance Officer. Reports may be made anonymously, without fear of retaliation or retribution. Failure to report known noncompliance or making reports which are not in good faith will be grounds for disciplinary action, up to and including termination. Reports related to harassment or other workplace-oriented issues, will be referred to Human Resources.

4. The Chapter will communicate its compliance standards and policies through required training initiatives to all staff members, contracted practitioners, and vendors. We are committed to these efforts through distribution of this Compliance Policy, our Code of Ethics and our Code of Conduct.

5. The Chapter is committed to maintaining and measuring the effectiveness of our Compliance Policies and Standards through monitoring and auditing systems reasonably designed to detect noncompliance by its staff members and agents. We shall require the performance of regular, periodic compliance audits by internal and/or external auditors who have expertise in federal and state health care statutes, regulations, and federal health care program requirements.

6. This Compliance Policy will be consistently enforced through appropriate disciplinary mechanisms, including, if appropriate, discipline of individuals responsible for failure to detect and/or report noncompliance.

7. Detected noncompliance, through any mechanism, i.e. compliance auditing procedures, confidential reporting, will be responded to in an expedient manner. We are dedicated to the resolution of such matters and will take all reasonable steps to prevent further similar violations, including any necessary modifications to the Compliance Program.

8. The Chapter will, at all times, exercise due diligence with regard to background and professional license investigations for all prospective staff members, contractors, vendors, and members of the Board of Directors.

Code of Ethics

It is the policy of the Chemung ARC to conduct all business in accordance with uncompromising ethical standards. We are committed to complying with all applicable laws and regulations. We believe integrity and trust are essential to the mission of serving our consumers. Adherence to such standards will not be traded or compromised for financial, professional or other business objectives.

We ensure that all aspects of consumer care and business conduct are performed in compliance with our mission/vision statement, policies and procedures, professional standards and applicable governmental laws, rules, regulations and other payor standards.

The Chapter expects every person who provides services to our consumers to adhere to the highest ethical standards and to promote ethical behavior. Any person whose behavior is found to violate ethical standards will be disciplined appropriately.

Staff members may not engage in any conduct that conflicts – or is perceived to conflict – with the best interest of the Chapter. Staff members must disclose any circumstances where the staff member or his or her immediate family member is an employee, consultant, owner, contractor or investor in any entity that (i) engages in any business or maintains any relationship with the Chapter; (ii) provides to, or receives from, the Chapter any consumer referrals; or (iii) competes with the Chapter. Staff members may not without permission of the Compliance Officer accept, solicit or offer anything of value from anyone doing business with the Chapter.

Staff members are expected to maintain complete, accurate and contemporaneous records as required by the Chapter. The term "records" includes all documents, both written and electronic, that relate to the provision of Chapter services or provide support for the billing of Chapter services. Records must reflect the actual service provided. Any records to be appropriately altered must reflect the date of the alteration, the name, signature and title of the person altering the document and the reason for the alteration if not apparent. No person shall ever sign the name of another person to any document. Signature stamps shall not be used. Backdating and predating documents is unacceptable and will lead to discipline up to and including termination.

When any person knows or reasonably suspects that the expectations above have not been met, this must be reported to supervisors, the Corporate Compliance Officer or the Executive Director, so each situation may be appropriately dealt with. The CCO may be reached at (607) 734-6151 extension 121 or the hotline at extension 555.

The Role of the Corporate Compliance Officer

The Board of Directors of Chemung ARC designates Mary Therese Owen as the Corporate Compliance Officer. The CCO has direct lines of communication to the Executive Director, the Board of Directors, and Chapter counsel. The Corporate Compliance Officer is a staff member and employee of the Chapter.

The CCO is directly obligated to serving the best interests of our Chapter, persons served and staff members. Responsibilities of the CCO include, but are not limited to:

1. Developing and implementing policies and procedures (P&P).

2. Overseeing and monitoring the implementation of the compliance plan.

3. Directing Chapter internal audits established to monitor effectiveness of compliance standards.

4. Providing guidance to management, medical/clinical personnel and individual departments regarding P&P and governmental laws, rules and regulations.

5. Updating, periodically, the compliance plan as changes occur within the Chapter, and/or in the requirements of law and regulations or governmental and third party payors.

6. Overseeing efforts to communicate awareness, the existence and contents of the compliance plan.

7. Coordinating, developing and participating in the educational and training program.

8. Guaranteeing independent contractors (consumer care, vendors, billing services, etc.) are aware of the requirements of the Chapter's compliance plan.

9. Actively seeking up-to-date material and releases regarding regulatory compliance.

10. Maintaining a reporting system (hotline) and responding to concerns, complaints and questions related to the compliance plan.

11. Acting as a resourceful leader regarding regulatory compliance issues.

12. Investigating and acting on issues related to compliance.

13. Coordinating internal investigations and implementing corrective action.

14. Serving as a member of the Corporate Compliance Committee and appearing as needed but at least quarterly before the Board to report on activities of the compliance program.

The Structure, Duties and Role of the Corporate Compliance Committee

The Corporate Compliance Officer (CCO) is appointed by the Executive Director and approved by the Board of Directors to advise and assist the CCC with the implementation of the CP.

The roles of the Corporate Compliance Committee include:

1. Analyzing the environment in which the Chapter does business, including legal requirements with which it must comply,

2. Reviewing and assessing existing P&P that address these risk areas for possible incorporation into the CP,

3. Working with departments to develop standards and P&P that address specific risk areas and encourage compliance according to legal and ethical requirements,

4. Advising and monitoring appropriate departments relative to compliance matters,

5. Developing internal systems and controls to carry out Compliance Standards (CS) and P&P,

6. Monitoring internal and external audits to identify potential non-compliant issues,

7. Implementing corrective and preventive action plans, and

8. Developing a process to solicit, evaluate and respond to complaints and problems.

Delegation of Substantial Discretionary Authority

Any staff member, prospective staff member, or member of the Board of Directors who holds, or intends to hold, a position with substantial discretionary authority for the Chapter, is required to disclose any name changes, and any involvement in non-compliant activities to the Chapter. In addition, the Chapter performs reasonable inquiries into the background of such applicants and also contractors and vendors.

Chapter Procedures HR – 020 and HR – 025, describe the Chapter's process for completion of Background Checks for Criminal History, Child Abuse Registry Checks and Medicare/Medicaid Exclusion Checks. The Chapter also has a Conflict of Interest procedure (CC – 025). All Board Members, the Executive Director, Leadership Team members and Finance Department staff must sign an annual Conflict of Interest Statement. All staff members will be appropriately credentialed prior to associating with the Chapter and while associated with the Chapter.

The Chapter will remove from direct responsibility or involvement in any federally or state-funded programs any staff member, independent contractor, or member of the Board of Directors who has participated in demonstrated non-compliant activities related to the provision of services; or is subject to actual or proposed exclusion from participation in federally or state-funded programs.

The following organizations have been queried with respect to all current employees, contractors, vendors and Members of the Board of Directors and will be queried with respect to potential employees, contractors, vendors and Members of the Board of Directors;

a) General services administration: list of parties excluded from federal programs. The URL address is http://www.epls.gov/epls/search.do.

b) HHS/OIG cumulative sanction report. The URL address is http://exclusions.oig.hhs.gov/search.html.

c) NYS Disqualified Providers List. The URL address is http://www.omig.state.ny.us/data/component/option,com_physiciandirectory/.

d) Licensure and disciplinary record with NYS Office of Professional Medical Conduct (Physicians, Physician Assistants) (the URL address is http://www.health.state.ny.us/nysdoh/opmc/main.htm) and/or New York State Department of Education (other licensed professionals) (the URL address is http://www.op.nysed.gov/rsearch.htm#name).

These databases will be queried upon hire/appointment to the Board and monthly for each employee and Member of the Board of Directors. All contractors and vendors will be queried upon contract and monthly in the first three databases, and those applicable, will be queried in the licensure sites as well.

Education and Training

Education and training are critical elements of the CP. Every staff member and agent is expected to be familiar and knowledgeable about the Chapter's CP and have a solid working knowledge of his or her responsibilities under the Plan. Compliance policies and standards will be communicated to all staff members through required participation in training programs.

All staff and members of the Board of Directors shall participate in training on the topics identified below:

- Government and private payor reimbursement principles,
- Government initiatives,
- History and background of Corporate Compliance
- Legal principles regarding compliance and Board responsibilities related thereto,
- General prohibitions on paying or receiving remuneration to induce referrals and the importance of fair market value,
- Prohibitions against submitting a claim for services when documentation of the service does not exist to the extent required,
- Prohibitions against signing for the work of another staff member,
- Prohibitions against alterations to medical records and appropriate methods of alteration,
- Prohibitions against rendering services without a signed physician's order or other prescription, as applicable,
- Proper documentation of services rendered, and
- Duty to report misconduct.

In addition to the above, targeted training will be provided to all managers and other staff members whose job responsibilities include activities related to compliance topics, such as coding and billing personnel. Managers shall assist the CCO in identifying areas that require specific training and are responsible for communication of the terms of this CP to all independent contractors doing business with the Chapter.

Within three months of hire, each staff member shall receive a written copy of the compliance plan, as part of their training. All contractors shall receive a copy of the Chapter Procedures related to the False Claims Act and Code of Conduct. Board Members shall receive a copy of the compliance plan as part of their Board Member orientation.

All education and training relating to the compliance plan will be verified by attendance and a signed acknowledgement of receipt of the Chapter's compliance plan and standards.

Training updates occur at least annually and periodically as needed. All appropriate staff (given the compliance topic) are required to attend as directed by the Chapter.

Attendance at compliance training sessions is mandatory and is a condition of continued employment.

Effective Confidential Communication

Open lines of communication between the CCO and every staff member and agent subject to this plan is essential to the success of our Compliance Program. Every staff member has an obligation to refuse to participate in any wrongful course of action and to report the actions according to the procedure listed below.

To report a violation of this CP:

If you witness, learn of, or are asked to participate in potential non-compliant activities, in violation of this CP, you must contact your supervisor, CCO or the Executive Director. Reports may be made in person or by calling a telephone line dedicated for the purpose of receiving such notification 734.6151 ext 121 or 555, mailing information to Mary Therese Owen, Corporate Compliance Officer, Chemung ARC, 711 Sullivan St., Elmira, NY 14901 or dropping it off at the office of the Corporate Compliance Officer located at the Sullivan St. office.

Your identity will be safeguarded to the fullest extent possible and you will be protected against retribution. A good faith report of any suspected violation of this plan by following the above shall not result in any retribution. Any threat of reprisal against a person who acts in good faith pursuant to his or her responsibilities under the Plan (including reporting; participating in an investigation; and assisting in a self-evaluation, audit or remedial action) is acting against the Chapter's Compliance Policy. Discipline, up to and including termination of employment or other association with the Chapter will result if such reprisal is confirmed.

Any staff member or agent may seek guidance with respect to the CP, Code of Ethics or Code of Conduct, at any time by following the reporting mechanisms outlined above.

Upon receipt of a question or concern, any supervisor, officer or director, shall document the issue at hand and report to the CCO. Any questions or concerns relating to potential non-compliance by the CCO should be reported immediately to the Executive Director.

The CCO or designee shall record the information necessary to conduct an appropriate investigation of all complaints. If the staff member was seeking information concerning the Code of Ethics or its application, the CCO or designee shall record the facts of the call, the nature of the information sought and respond as appropriate. The Chapter shall, as much as is possible, protect the anonymity of the staff member or contractor who reports any complaint or question.

Enforcement of Compliance Standards

Staff members who fail to comply with the Chapter's Compliance Policy and Standards, or who have engaged in conduct that has the potential of impairing the Chapter's status as a reliable, honest, and trustworthy health care provider will be subject to disciplinary action, up to and including termination.

Staff members may be subject to discipline for the following infractions:

- Failing to report suspected compliance issues
- Participating in non-compliant behavior
- Encouraging, directing, facilitating or permitting either activity or passively non-compliant behavior.

Any discipline will be appropriately documented in the staff member's personnel file, along with a written statement of the reason(s) for imposing such discipline. The CCO shall maintain a record of all disciplinary actions involving the Compliance Plan and report at least quarterly to the Board of Directors regarding such actions.

Auditing and Monitoring

Ongoing evaluation is critical in detecting non-compliance and will help ensure the success of the Chapter's compliance program. An ongoing auditing and monitoring system, implemented by the CCO, in consultation with the CCC, is an integral component of our auditing and monitoring systems. This ongoing evaluation shall include the following:

- Review of relationships with third-party contractors, specifically those with substantive exposure to government enforcement actions,

- Compliance audits of P&P and Code of Ethics as stated in the Plan, conducted by the CCO, and

- Review of documentation and billing relating to Medicaid and Medicare claims development and submission performed internally or by an external consultant as determined by the CCO and CCC. The audit results shall be documented by the CCO. The Program Director shall prepare a Management Response. The audit results and Management Response shall together be presented to the Corporate Compliance Committee.

- Should a Quality issue become evident that would impact the Corporate Compliance Program at Chemung ARC, including, but not limited to those that might impact the reimbursement of services, that issue will be brought to the attention of the Corporate Compliance Committee. The Committee shall discuss the issue and determine an appropriate course of action.

The audits and reviews will examine the Chapter's compliance with specific rules and policies through on site visits, personnel interviews, general questionnaires (submitted to staff members and contractors), medical and clinical record reviews to support claims for Medicaid/Medicare reimbursement, and documentation reviews.

Additional steps to ensure the integrity of the CP will include:

- Annual review with legal counsel of all records of communications and reports by all staff members or contractors kept in accordance with this Plan,

- Any correspondence from any regulatory agency charged with administering a federally or state-funded program received by any department of the Chapter shall be immediately copied and forwarded to the CCO for review and discussion by the CCC,

- Immediate notification of the CCO of any visits, audits, investigations or surveys by any federal, state or county agency or authority, and

Establishment of a process detailing ongoing notification by the CCO to all appropriate personnel of any changes in laws, regulations or policies, as well as appropriate training to assure continuous compliance.

Detection and Response

The CCO, Executive Director and the CCC shall determine whether there is any basis to suspect that a violation of the CP has occurred.

If it is determined that a violation ***may have*** occurred, the matter shall be discussed with legal counsel, who will, with the CCO, concur on a plan of action and decide whether a more detailed investigation is warranted. This investigation may include, but is not limited to, the following:

- Interviews with individuals having knowledge of the facts alleged,
- A review of documents, and
- Legal research and contact with governmental agencies for the purpose of clarification.

If advice is sought from a governmental agency or fiscal intermediary or carrier, the request and any written or oral response shall be fully documented.

At the conclusion of an investigation involving legal counsel, he/she shall issue a report to the CCO, Executive Director, and CCC summarizing his or her findings, conclusions and recommendations and will advise if the facts indicate that a violation of the law has occurred.

The report will be reviewed with legal counsel in attendance. Any additional action will be on the advice of counsel.

If the Chapter identifies that an overpayment was received from any third party payer, the appropriate regulatory (funder) and/or prosecutorial (attorney general/police) authority will be appropriately notified with the advice and assistance of counsel. It is our policy to not retain any funds which are received as a result of overpayments. In instances where it appears an affirmative fraud may have occurred, appropriate amounts shall be returned after consultation and approval by involved regulatory and/or prosecutorial authorities. Systems shall also be put in place to prevent such overpayments in the future.

Regardless of whether a report is made to a governmental agency or prosecutorial authority, the CCO shall maintain a record of the investigation, including copies of all pertinent documentation. A Corporate Compliance Log will be kept by the CCO, as described in Chapter procedure CC – 030, to document any corporate compliance concerns and the follow-up taken. This record will be considered confidential and privileged and will not be released without the approval of the Executive Director or legal counsel.

The CCO shall report to the CCC regarding each investigation conducted.

Code of Conduct

All staff members, contractors and Board Members of Chemung ARC, are expected to follow the Code of Conduct. Each person is expected to sign an Acknowledgement Form for receipt and review of the Code of Conduct.

Supervisors are expected to set a positive example for staff, particularly with respect to the Code of Conduct. We expect supervisors to create an environment where all staff feel free to raise concerns and propose ideas. We expect that supervisors will ensure that staff have sufficient information to comply with laws, regulations and Chapter procedures. Supervisors must maintain a culture which promotes the highest standards of ethics and compliance.

Chemung ARC has a commitment to:

1. The People We Support: We are committed to providing the highest quality of care, in a caring and compassionate manner.

2. The Communities We Support: We are committed to understanding the unique needs of the people we ssupport and to provide our services in a cost-effective and quality manner.

3. Our Staff Members: We are committed to a work setting which is safe, which treats all staff with fairness, dignity and respect, which affords all staff an opportunity to grow, to develop professionally and to work in a team environment where all ideas are considered.

4. Our Third Party Payors: We are committed to working with our payors in a way that demonstrates our commitment to our contractual obligations and reflects our shared concerns for quality services provided in an efficient and effective manner. We encourage our payors to adopt their own set of ethical principles that recognize their obligations to the people we serve, as well as the need for fairness between providers and payors.

5. Our Regulators: We are committed to creating an environment in which compliance with applicable rules, laws and regulations is woven into the fabric of Chemung ARC. We accept responsibility to self-govern and monitor adherence to requirements of law and our Code of Conduct.

6. Our Suppliers: We are committed to fair competition among existing and prospective suppliers. We encourage our suppliers to adopt their own set of standards and ethical practices.

Rules of Conduct

Chemung ARC believes that certain rules of conduct must be observed to promote a positive and ethical work environment and pledges to abide by laws, regulations and Chapter procedures, particularly those related to the Chapter's Corporate Compliance Plan.

As people who are working for and on behalf of Chemung ARC, we have the added responsibility of following specific rules of conduct, as follows:

- To work cooperatively and respectfully with all Chemung ARC staff, Board Members and agents to provide the highest quality of services;
- To place the interests of the people we serve and their family members first and foremost in all aspects of what we do. This shall specifically include the following:
    - People shall not engage in any activity that constitutes abuse of the people we serve;
    - The people we serve shall not carry out the duties of staff members;
    - The people we serve shall not be subject to inappropriate exposure to firearms or other weapons in or on the grounds of the agency. *(This does not preclude a person served from pursuing the opportunity to attend hunter safety training.)* Firearms and other weapons are not permitted to be stored on the grounds of the agency;
    - Financial transactions between the people we serve and staff shall be prohibited; and
    - Staff need to model appropriate behavior to the people we serve;
- To represent Chemung ARC positively, truthfully and accurately in the community;
- To conduct all activities in a fiscally responsible manner;
- To work in accordance with applicable laws, regulations, and Chapter procedures;
- To refrain from distributing, selling, possessing, purchasing or consuming illegal substances or alcohol while at work; this also precludes attending work while under the influence of alcohol, and/or illegal or legal substances, that would impair work performance;
- To seek training and assistance in areas that would strengthen the ability to fulfill responsibilities to the people we serve and Chemung ARC;
- To refrain from discriminatory or harassing behaviors for any reason, and to refrain from the use of obscene, abusive or threatening language and gestures, fighting and gambling;
- To avoid conflicts of interest, including acceptance and giving of gifts; this shall include that gifts shall not be offered to potential referral sources, or their families;
- Potential referral sources shall not receive financial benefits to increase the volume of referrals to the Chapter;
- To conserve resources of Chemung ARC by not engaging in wasteful behavior;
- To treat confidential information appropriately and respect the privacy of the people we serve and our staff. Confidential information shall only be utilized in a professional manner and subject to relevant laws and regulations;
- To complete tasks in a timely manner and meet the quality expectations of the Chapter;
- To bill individuals and third party payors accurately;
- To report to a supervisor or to the Compliance Hotline (Ext. 555), any potential violation of applicable laws, regulations and procedures, including the Corporate Compliance Plan;
- To respect the role of the Board and management staff and to fully implement their decisions; and
- To consult Chemung ARC leadership staff when questions arise regarding the conduct permitted under applicable laws, regulations and policies, including the Corporate Compliance Plan.

False Claims Act and OMIG Certification

I. Definitions

Chemung ARC is committed to prompt, complete and accurate billing of all services provided. The Chapter is also committed to detecting and preventing fraud, waste and abuse in the federal and state programs.

A. Federal Law

The False Claims Act is a Federal Law. The government utilizes it to prevent and detect fraud, waste and abuse in federal healthcare programs. Because Chemung ARC bills Medicaid and Medicare, the Chapter is expected to uphold the False Claims Act.

The Act states that anyone who "knowingly" submits false claims to the government is liable for damages up to three times the amount of the erroneous claim plus mandatory penalties between $10,781 and $21,563 for each false claim submitted.
"Knowingly" is defined as the person either:

a. has knowledge of the false claim;
b. acts in deliberate ignorance of the truth or falsity of the information; or
c. acts in reckless disregard of the truth or falsity of the information.

The False Claims Act may be violated by the following acts:

a. Knowingly presenting or causing to be presented, a false or fraudulent claim for payment or approval by the federal Government;
b. Knowingly making or using or causing to be made or used, a false record or statement to get a false claim paid or approved;
c. Conspiring to defraud the Government by getting a false or fraudulent claim allowed or paid; or
d. Knowingly making, using or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay money or transmit property to the Government.

Some examples of actions that violate the False Claims Act include:

a. Billing for services that were not actually rendered
b. Charging more than once for the same service
c. Falsifying time records used to bill Medicaid.

B. New York State Laws

1. *The NY False Claims Act* closely resembles the Federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including Medicaid. The penalty for filing a false claim is $6,000 - $12,000 per claim and the recoverable damages are between two and three times the value of the amount falsely recovered. In addition, the false claim filer may have to pay the government's legal fees.

2. *Social Services Law 145-c* refers to a person who applies for or receives, public assistance. If a person intentionally makes a false statement in order to receive services, penalties will be assessed.

Chemung ARC staff shall assist persons served as needed and able, in order to assure that persons served are in compliance with the law.

3. *Social Services Law 366-b* refers to a person who mis-represents services delivered in order to receive a higher payment for service than to what he/she is entitled. He/she shall be guilty of a class A misdemeanor.

4. *Penal Law 177* establishes the crime of Health Care Fraud. When a person commits Health Care Fraud – it is a crime. It is punishable with fines and jail time.

5. *Labor Law 740* states that an employer may not take any retaliatory action against a staff member because the staff member:

- ◊ Discloses or threatens to disclose to a supervisor or to a public body, an activity, policy or practice of the Chapter that is in violation of a law or regulation; OR
- ◊ Provides information to or testifies before, a public body in regard to an employer's violation of a law or regulation; OR
- ◊ Objects to, or refuses to, participate in any act not consistent with a law or regulation.

6. *Labor Law 741* states that no employer shall take retaliatory action because the employee:

- ◊ Discloses or threatens to disclose to a supervisor or to a public body, an activity, policy or practice of Chemung ARC that the staff in good faith, reasonably believes constitutes improper quality of care of persons supported.
- ◊ Objects to or refuses to participate in any activity that the staff member, in good faith, believes to constitute improper quality of care.

The protection against retaliatory action shall not apply unless the staff member has brought the improper quality of care issue to the attention of his/her supervisor and has afforded Chemung ARC reasonable opportunity to correct the issue.

7. *OMIG Certification*

Oversight of the New York State False Claims Act will be the responsibility of the Office of the Medicaid Inspector General (OMIG). Each agency is required to submit to OMIG on or before October 1, 2007, and on or before January 1, every year thereafter, a certification that:

- ◊ it maintains the written policies related to the False Claims Act

and

- ◊ the staff handbook includes materials;

,required under the Deficit Reduction Act mandates and that they have been properly adopted and published by the Chapter, and disseminated among staff, contractors and agents.

The written procedures and staff handbooks shall be maintained for a period of at least ten years.

The above summary is not meant to be exhaustive. Attached please find additional information prepared by the New York State Office of the Medicaid Inspector General for your review and information.

II. Expectations

It is expected that all staff members of Chemung ARC will comply with both the Federal and State laws concerned with the filing of false claims. It is also expected that if a staff member becomes aware that anyone else in the Chapter is engaging in false billing practices, that the staff member will bring it to the attention of a supervisor or to the Corporate Compliance Officer.

If a staff member brings an action on behalf of either the Federal Government or New York State, the Government has a period of time to investigate. If the Government joins the lawsuit, the staff member may be entitled to 15-25% of the recovery. If the Government elects not to join the lawsuit, and the staff member continues, the staff member may be eligible for 25 -30% of the recovered amount.

III. Whistleblower Protection

The Chapter will not retaliate against any staff member for reporting any good faith potential compliance concern, as noted in the Chapter's Staff Handbook.

No Director, officer, staff member or volunteer of the agency, who in good faith reports any action or suspended action taken by or within the agency that is illegal, fraudulent, or in violation of any adopted policy of the agency, shall suffer intimidation, harassment, discrimination or other retaliation or adverse employment consequences for staff members.

Reporting of events shall occur following the agency's "Confidential Communication Procedure: CC-020".

The agency's Corporate Compliance Officer is the designated as the Board liaison for this purpose. The CCO shall administer this procedure and report to the Board as appropriate. Directors who are staff members cannot participate in an Board or committee deliberations or voting relative to administering the whistleblower procedure.
The person who is the subject of the whistleblower complaint may not be present or participate in the Board or committee deliberations or vote on the matter (except that nothing prohibits the person from providing background information or answering questions before deliberations/voting begin).

This information is also available in the Staff Handbook and on the Agency's website in the Agency' Corporate Compliance Plan.

The Act prohibits discrimination against a staff member for taking lawful actions in regard to the False Claims Act (aka. qui tam relator). A staff member cannot be discharged, demoted, harassed or otherwise be discriminated against if the staff member reports a potential fraudulent event. If the Agency committed any of those acts, the staff member may be entitled to relief in the form of reinstatement, double back pay and compensation for any special damages, including litigation costs and reasonable attorney's fees.

Numerous laws prohibit discrimination against a staff member for taking lawful actions in regard to the False Claims Act (including becoming a qui tam relator). A staff member cannot be discharged, demoted, harassed or otherwise be discriminated against if the staff member reports a potential fraudulent event in good faith. If the Chapter committed any of those acts, the staff

member may be entitled to relief in the form of reinstatement, double back pay and compensation for any special damages, including litigation costs and reasonable attorney's fees.

IV. Contractors

Contractors are also subject to the False Claims Act. A copy of this procedure shall be attached to all contracts for outside contractors and agents.

V. Board Members

Board Members shall also be made aware of the Federal and NYS False Claims Acts as part of the Board Orientation Program.

Voluntary Disclosure

Chemung ARC intends to respond appropriately and swiftly to violations of the law, regulations and/or the Chapter's Corporate Compliance Plan in order to protect the Chapter and to maintain Chemung ARC's trustworthy reputation.

If the Chapter has confirmed that a violation has taken place, then corrective action will be taken. Notification to government officials will be considered with the consult of legal representation.

Identification of a Violation

If a violation is identified, it will generally be brought to the attention of the Corporate Compliance Officer (CCO). An individual may instead bring the issue to the Corporate Compliance Committee or the Executive Director.

The violation may have been identified through various avenues, including but not limited to: conversations between staff and the CCO, calls to the Hotline (ext 555), internal audits or outside investigations, audits or surveys.

Chapter Response to the Violation

The CCO will attempt to verify that a violation of the Corporate Compliance Plan, or state or federal law or regulation has taken place. The CCO will then (as appropriate) discuss the issue with the Executive Director and Legal Counsel. The CCO will then:

- ◊ with the appropriate Leadership Team member, develop and implement a Plan of Corrective Action
- ◊ Notify the Corporate Compliance Committee
- ◊ Resolve any issues of overpayment
- ◊ Consult with Legal Counsel regarding notification of State or Federal Regulatory or Prosecutorial agencies.

Once the Corrective Action Plan has been developed, it should be approved by appropriate parties which may include the Executive Director, the Corporate Compliance Committee and/or the Board of Directors, depending on the severity of the violation.

Regular Progress Reports should be presented to the Corporate Compliance Committee to ensure that the plan is being implemented as designed.

The Chapter will make every effort to comply with applicable statutes, regulations and federal program requirements. The Chapter shall also document these efforts.

Voluntary Disclosure of Violations

The CCO, in consultation with the Executive Director, Corporate Compliance Committee and Legal Counsel, will evaluate the alleged violation to determine if a voluntary disclosure is appropriate. The disclosure may be to government officials, third party payors or other entities. Notification shall be made within a reasonable timeframe after discovering the violation. It may include return of monies previously paid to the Chapter.

PPACA - Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act was signed into Federal Law in March 2010 by President Obama. Section 6402 of PPACA refers to Medicare and Medicaid Program Integrity Provisions. Section 6402 (d) discusses the reporting and returning of overpayments. It is expected that Chemung ARC will adhere to the requirements of PPACA.

In general, if a person has received an overpayment, the person shall **report and return** the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address;
And
Notify the Secretary, State, intermediary, carrier or contractor, to whom the overpayment was returned in writing of the reason for the overpayment.

In New York, overpayments should be returned, reported and explained to OMIG at:

Office of the Medicaid Inspector General
800 North Pearl Street
Albany, NY 12204

An overpayment is defined as "any funds that a person receives or retains under Medicare or Medicaid to which the person, after applicable reconciliation, is **not entitled** under Medicare or Medicaid. (Not entitled means: kickback, Stark Law, Eligibility, Conditions of Payment).

An overpayment must be reported and returned by the later of:

a. The date which is 60 days after date on which the overpayment was identified; or
b. The date on which any corresponding cost report is due, if applicable

Overpayments may be caused by a variety of issues such as:

- Duplicate payments for the same service
- Services not actually rendered
- Patient is deceased
- Practitioner lacked required license or certification or has been excluded
- Billing system error
- No order for the service
- Service not documented as required by regulation

If a person knowingly does not report an overpayment, the False Claims Act could apply.

OMIG does state: "OMIG is not interested in fundamentally altering the day to day business processes of organizations for minor or insignificant matters. Consequently, the repayment of simple, more routine occurrences of overpayment should continue through typical methods of resolution, which may include voiding or adjusting the amounts of claims."

(*The information for this section was taken from the OMIG presentation dated July 2010.*)

Physician Arrangements

The Chapter may enter into financial arrangements with physicians in order to meet the needs of the people we serve. All such arrangements must be structured in light of federal and state laws. There are three categories of potential financial relationships with physicians who also act as referral sources that the Chapter may undertake: 1. Employment Agreements, 2. Personal Service Agreements and 3. Equipment and Space Rental Arrangements.

If a program desires to enter into a financial arrangement with a physician (ex. Medical Director), the program shall work with the Corporate Compliance Officer to ensure that the arrangement meets federal and state laws. All contracts of this nature shall be reviewed by counsel to ensure compliance as well.

All arrangements shall be in writing and be for a term of at least one year.

All arrangements must be undertaken without regard to the value or volume of physician referrals and must not include any intention to induce referrals. Payments will be fair market value.

Copies of all contracts are to be kept in a central location in the Business Office.
When the Chapter identifies the need for a Physician Agreement, the Chapter shall utilize Procedure CC – 080, Physician Arrangements as a guide for development of the contract.

FEDERAL & NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS

I. FEDERAL LAWS

False Claims Act (31 USC §§3729-3733)

The False Claims Act ("FCA") provides, in pertinent part, that:

> (a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government;. . . or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,
>
> ***
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person . . . .
>
> (b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

31 U.S.C. § 3729. While the False Claims Act imposes liability only when the claimant acts "knowingly," it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act. 31 U.S.C. 3729(b).

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) is false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called "reverse false claim" may include a hospital who obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. 31 U.S.C. 3730 (b). These private parties, known as "*qui tam* relators," may share in a percentage of the proceeds from an FCA action or settlement.

Section 3730(d)(1) of the FCA provides, with some exceptions, that a qui tam relator, when the Government has intervened in the lawsuit, shall receive at least 15 percent but not more than 25 percent of the proceeds of the FCA action depending upon the extent to which the relator substantially contributed to the prosecution of the action. When the Government does not intervene, section 3730(d)(2) provides that the relator shall receive an amount that the court decides is reasonable and shall be not less than 25 percent and not more than 30 percent.

Administrative Remedies for False Claims (31 USC Chapter 38. §§ 3801 – 3812)

This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, then the agency receiving the claim may impose a penalty of up to $5,000 for each claim. The agency may also recover twice the amount of the claim.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted, not when it is paid. Also unlike the False Claims Act, the determination of whether a claim is false, and the imposition of tines and penalties is made by the administrative agency, not by prosecution in the federal court system.

II. NEW YORK STATE LAWS

New York's false claims laws fall into two categories: civil and administrative; and criminal laws. Some apply to recipient false claims and some apply to provider false claims, and while most are specific to healthcare or Medicaid, some of the "common law" crimes apply to areas of interaction with the government.

A. CIVIL AND ADMINISTRATIVE LAWS

NY False Claims Act (State Finance Law, §§187-194)

The NY False Claims Act closely tracts the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. The penalty for filing a false claim is $6,000 -$12,000 per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may have to pay the government's legal fees.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties. If the suit eventually concludes with payments back to the government, the person who started the case can recover 25-30% of the proceeds if the government did not participate in the suit of 15-25% if the government did participate in the suit.

Social Services Law §145-b False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The State or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $2,000 per violation. If repeat violations occur within 5 years, a penalty up to $7,500 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

Social Services Law §145-c Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the person's, the person's family's needs are not taken into account for 6 months if a first offense, 12 months if a second (or once if benefits received are over $3,900) and live years for 4 or more offenses.

B. CRIMINAL LAWS

Social Services Law §145 Penalties

Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

Social Services Law § 366-b, Penalties for Fraudulent Practices.

a. Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a Class A misdemeanor.

b. Any person who, with intent to defraud, presents for payment and false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a Class A misdemeanor.

Penal Law Article 155, Larceny.

The crime of larceny applies to a person who, with intent to deprive another of his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud, or other similar behavior. It has been applied to Medicaid fraud cases.

a. Fourth degree grand larceny involves property valued over $1,000. It is a Class E felony.

b. Third degree grand larceny involves property valued over $3,000. It is a Class D felony.

c. Second degree grand larceny involves property valued over $50,000. It is a Class C felony.

d. First degree grand larceny involves property valued over $1 million. It is a Class B felony.

Penal Law Article 175, False Written Statements.

Four crimes in this Article relate to filing false information or claims and have been applied in Medicaid fraud prosecutions:

a. §175.05, Falsifying business records involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. It is a Class A misdemeanor.

b. § 175.10, Falsifying business records in the first degree includes the elements of the §175.05 offense and includes the intent to commit another crime or conceal its commission. It is a Class E felony.

c. §175.30, Offering a false instrument for filing in the second degree involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information. It is a Class A misdemeanor.

d. §175.35, Offering a false instrument for filing in the first degree includes the elements of the second degree offense and must include an intent to defraud the state or a political subdivision. It is a Class E felony.

Penal Law Article 176, Insurance Fraud,

Applies to claims for insurance payment, including Medicaid or other health insurance and contains six crimes.

a. Insurance Fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.

b. Insurance fraud in the 4th degree is filing a false insurance claim for over $1,000. It is a Class E felony.

c. Insurance fraud in the 3rd degree is filing a false insurance claim for over $3,000. It is a Class D felony.

d. Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. It is a Class C felony.

e. Insurance fraud in the 1st degree is filing a false insurance claim for over $1 million. It is a Class B felony.

f. Aggravated insurance fraud is committing insurance fraud more than once. It is a Class D felony.

Penal Law Article 177, Health Care Fraud,

Applies to claims for health insurance payment, including Medicaid, and contains five crimes:

a. Health care fraud in the 5th degree is knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions. It is a Class A misdemeanor.

b. Health cam fraud in the 4th degree is filing false claims and annually receiving over $3,000 in aggregate. It is a Class E felony.

c. Health care fraud in the 3rd degree is filing false claims and annually receiving over $10,000 in the aggregate. It is a Class D felony.

d. Health care fraud in the 2nd degree is filing false claims and annually receiving over $50,000 in the aggregate. It is a Class C felony.

e. Health care fraud in the 1st degree is filing false claims and annually receiving over $1 million in the aggregate. It is a Class B felony.

III. WHISTLEBLOWER PROTECTION

Federal False Claims Act (31 U.S.C. §3730(h))

The FCA provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. 3730(h). Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

NY False Claim Act (State Finance Law §191)

The False Claim Act also provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the Act. Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

New York Labor Law §740

An employer may not take any retaliatory action against an employee if the employee discloses information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that the employer is in violation of a law that creates a substantial and specific danger to the public health and safety or which constitutes health care fraud under Penal Law §177 (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions). The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

New York Labor Law §741

A health care employer may not take any retaliatory action against an employee if the employee discloses certain information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care. The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, unless the danger is imminent to the public or patient and the employee believes in good faith that reporting to a supervisor would not result in corrective action. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.